TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Reece Hayden, D.C.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-17-1606-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
January 27, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DR REFERRED TESTING NO PAYMENT RECEIVED"

Amount in Dispute: $851.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester billed for a functional capacity evaluation provided on the date above. The requestor's documentation does not include cardiovascular endurance tests which measure aerobic capacity using a stationary bicycle or treadmill."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 31, 2016	Functional Capacity Evaluation (97750-FC)	$851.04	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.225 sets out the fee guidelines for functional capacity evaluations performed on or after September 1, 2016.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - A07 – Documentation does not meet the level of service required for FCE per Rule 134.204(g)3(C)
   - CAC-150 – Payer deems the information submitted does not support this level of service.

Issues

Are Texas Mutual Insurance Company's reasons for denial of payment supported?

Findings

Reece Hayden, D.C. is seeking reimbursement of $851.04 for a functional capacity evaluation performed on October 31, 2016. Texas Mutual Insurance Company (Texas Mutual) denied this service with claim adjustment reason codes A07 – "DOCUMENTATION DOES NOT MEET THE LEVEL OF SERVICE REQUIRED FOR FCE PER RULE 134.204(G)3(C)," and CAC-150 – "PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE." Texas Mutual supported the denials in its position statement, stating that "The requestor's documentation does not include cardiovascular endurance tests which measure aerobic capacity using a stationary bicycle or treadmill."

Documentation requirements for a functional capacity evaluation are found in 28 Texas Administrative Code §134.225, which states that FCEs shall include …

(3) Functional abilities tests, which include the following:
  (A) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);
  (B) hand function tests that measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices;
  (C) **submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill** [emphasis added]; and
  (D) static positional tolerance (observational determination of tolerance for sitting or standing).

Review of the submitted documentation does not support that a submaximal cardiovascular endurance test measuring aerobic capacity using a stationary bicycle or treadmill was performed. The division concludes that Texas Mutual's denial of payment for the disputed services is supported. No reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	March 31, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.